		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027458

Facility Name: Manorcare at Decatur

Address: 444 West Harrison Street (Number) Decatur (City) 62526 (Zip Code)

County: Macon

Telephone Number: (217) 877-7333 **Fax #** (217) 872-6723

HFS ID Number: 520886946005

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT	[X] PROPRIETARY		[ ] GOVERNMENTAL	
[ ] Charitable Corp.	[ ] Individual		[ ] State	
[ ] Trust	[ ] Partnership		[ ] County	
IRS Exemption Code	[X] Corporation		[ ] Other	
	[ ] "Sub-S" Corp.			
	[ ] Limited Liability Co.			
	[ ] Trust			
	[ ] Other			

In the event there are further questions about this report, please contact:
Name: Craig Dekany, CPA **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/04 to 05/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President of Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 03/15/05

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	112	38,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	112	38,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	725	17,444	9,853	28,022	8
9	SNF/PED					9
10	ICF	7,534			7,534	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,259	17,444	9,853	35,556	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.20%

D. How many bed-hold days during this year were paid by the Department? 68 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 112 and days of care provided 9,061

Medicare Intermediary Care First of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/05 Fiscal Year: 05/31/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at Decatur # 0027458 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	180,135	15,054	14,827	210,016	1,731	211,747		211,747			1
2	Food Purchase		183,073		183,073		183,073	(2,115)	180,958			2
3	Housekeeping	96,318	19,054	4,008	119,380		119,380		119,380			3
4	Laundry	39,484	9,617	369	49,470		49,470		49,470			4
5	Heat and Other Utilities			107,622	107,622	3,993	111,615	(1,533)	110,082			5
6	Maintenance	45,381	10,870	43,877	100,128		100,128		100,128			6
7	Other (specify):*			1,043	1,043		1,043		1,043			7
8	**TOTAL General Services**	361,318	237,668	171,746	770,732	5,724	776,456	(3,648)	772,808			8
	B. Health Care and Programs											
9	Medical Director			27,600	27,600		27,600		27,600			9
10	Nursing and Medical Records	1,649,192	130,446	35,225	1,814,863	29,524	1,844,387	(4,065)	1,840,322			10
10a	Therapy	180,330	7,063	143,300	330,693		330,693		330,693			10a
11	Activities	71,775	3,165	3,171	78,111		78,111	(5,730)	72,381			11
12	Social Services	100,501		1,619	102,120		102,120		102,120			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,001,798	140,674	210,915	2,353,387	29,524	2,382,911	(9,795)	2,373,116			16
	C. General Administration											
17	Administrative	78,332		279,864	358,196	(122,237)	235,959		235,959			17
18	Directors Fees											18
19	Professional Services			287	287		287	(287)				19
20	Dues, Fees, Subscriptions & Promotions			37,034	37,034		37,034	(19,358)	17,676			20
21	Clerical & General Office Expenses	121,287	42,772	62,521	226,580		226,580	(39,118)	187,462			21
22	Employee Benefits & Payroll Taxes			506,807	506,807	27,143	533,950		533,950			22
23	Inservice Training & Education			3,119	3,119		3,119		3,119			23
24	Travel and Seminar			8,024	8,024		8,024		8,024			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			107,907	107,907		107,907		107,907			26
27	Other (specify):*											27
28	**TOTAL General Administration**	199,619	42,772	1,005,563	1,247,954	(95,094)	1,152,860	(58,763)	1,094,097			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,562,735	421,114	1,388,224	4,372,073	(59,846)	4,312,227	(72,206)	4,240,021			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Decatur #0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			294,785	294,785	11,805	306,590		306,590			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					48,041	48,041	(4,092)	43,949			32
33	Real Estate Taxes			77,138	77,138		77,138	(24,043)	53,095			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,693	19,693		19,693		19,693			35
36	Other (specify):*											36
37	**TOTAL Ownership**			391,616	391,616	59,846	451,462	(28,135)	423,327			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		248,092	28,845	276,937		276,937		276,937			39
40	Barber and Beauty Shops			16,345	16,345		16,345		16,345			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,845	55,845		55,845		55,845			42
43	Other (specify):* **Therapy Drugs**		19,380		19,380		19,380		19,380			43
44	**TOTAL Special Cost Centers**		267,472	101,035	368,507		368,507		368,507			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,562,735	688,586	1,880,875	5,132,196		5,132,196	(100,341)	5,031,855			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$ (5,730)	11	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,115)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,533)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,092)	32		10
11	Discounts, Allowances, Rebates & Refunds	9	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,065)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(511)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(287)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,470)	21		24
25	Fund Raising, Advertising and Promotional	(19,358)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(24,043)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,146)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (100,341)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (100,341)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Manorcare at Decatur

ID# 0027458

Report Period Beginning: 06/01/04

Ending: 05/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Customer Reimbursement	$ (2,031)	21	1
2	Admit Fees	(115)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,146)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Decatur # 0027458 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,115)	0	0	0	0	0	0	0	0	0	0	(2,115)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,533)	0	0	0	0	0	0	0	0	0	0	(1,533)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,648)	0	0	0	0	0	0	0	0	0	0	(3,648)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,065)	0	0	0	0	0	0	0	0	0	0	(4,065)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,730)	0	0	0	0	0	0	0	0	0	0	(5,730)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(9,795)	0	0	0	0	0	0	0	0	0	0	(9,795)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(287)	0	0	0	0	0	0	0	0	0	0	(287)	19
20	Fees, Subscriptions & Promotions	(19,358)	0	0	0	0	0	0	0	0	0	0	(19,358)	20
21	Clerical & General Office Expenses	(39,118)	0	0	0	0	0	0	0	0	0	0	(39,118)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(58,763)	0	0	0	0	0	0	0	0	0	0	(58,763)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(72,206)	0	0	0	0	0	0	0	0	0	0	(72,206)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Manorcare at Decatur** **#** **0027458** **Report Period Beginning:** **06/01/04** **Ending:** **05/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,092)	0	0	0	0	0	0	0	0	0	0	(4,092)	32
33	Real Estate Taxes	(24,043)	0	0	0	0	0	0	0	0	0	0	(24,043)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(28,135)	0	0	0	0	0	0	0	0	0	0	(28,135)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(100,341)	0	0	0	0	0	0	0	0	0	0	(100,341)	45

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
	100	Health Care & Retirement Corporation	Toledo, OH			
Manor Care, Inc.		of America				
		(See H.O. Cost Report)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 279,864	HCR Manor Care, Inc	100.00%	$ 279,864	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	13,329	Heartland Management Services	100.00%	13,329		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 293,193			$ 293,193	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc
Street Address: 333 North Summit St
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	1,043,233	571,891	4,694,190	1,731	2
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	223,707	223,707	4,694,190	444	3
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	2,139,042		4,694,190	3,549	4
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	12,987,607	12,987,607	4,694,190	25,787	5
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	2,252,260	1,199,059	4,694,190	3,737	6
7	17	General & Admin - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	16,611,639	16,611,639	4,694,190	32,982	7
8	17	General & Admin - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	75,121,310	43,509,256	4,694,190	124,645	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	3,924,545	3,924,545	4,694,190	7,792	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	11,662,215		4,694,190	19,351	10
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac			4,694,190	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	7,114,804		4,694,190	11,805	12
13										13
14	32	Interest				10,002,527			48,041	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 143,082,889	$ 79,027,704		$ 279,864	25

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv Sub Debentures		X	Facility			$ 738,560	$ 738,560			$ 48,041	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8								Interest Income			(4,092)	8
9	TOTAL Facility Related						$ 738,560	$ 738,560			$ 43,949	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 738,560	$ 738,560			$ 43,949	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Manorcare at Decatur **#** 0027458 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	50,881	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	26,838	2
3. Under or (over) accrual (line 2 minus line 1).	$	(24,043)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	77,138	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	53,095	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	43,881	8
	2001	45,959	9
	2002	50,833	10
	2003	53,677	11
	2004	51,425	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Decatur COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0027458

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 858-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-03-451-010	See Attached	$ 24,515.12	$ 24,515.12
2.	04-12-03-451-013	See Attached	$ 511.85	$ 511.85
3.	04-12-03-451-016	See Attached	$ 685.71	$ 685.71
4.	04-12-03-451-010	See Attached	$ 24,515.12	$ 24,515.12
5.	04-12-03-451-013	See Attached	$ 511.85	$ 511.85
6.	04-12-03-451-016	See Attached	$ 685.71	$ 685.71
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 51,425.36	$ 51,425.36

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,108 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1981	$ 208,393	1
2	Facility		2005	37,451	2
3	TOTALS			$ 245,844	3

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	96			1963	$ 659,655	$ 89,109		$ 89,109	$	$ 1,659,052	4
5	6			2003	682,385						5
6				2003	(201,827)						6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)					117,228		117,228		1,038,752	9
10				1983	102,669						10
11				1984	5,247						11
12				1985	4,600						12
13				1986	9,308						13
14				1987	92,366						14
15				1988	38,377						15
16				1989	18,196						16
17				1990	6,261						17
18				1991	162,665						18
19				1992	121,887						19
20				1993	191,712						20
21				1994	75,641						21
22				1995	47,351						22
23	A/C WALL SLEEVE UNIT			1995	2,952						23
24	INSTALL FIRE BOXES			1995	513						24
25	ELECTRICAL			1995	7,058						25
26	HANDRAILS			1995	8,442						26
27	CONCRETE FLOOR			1995	884						27
28	ARCHITECT-ARCADIA / LOBBY			1995	1,439						28
29	LIGHTING			1995	4,074						29
30	FLOORING			1995	2,080						30
31	NURSE CALL SYSTEM			1995	38,400						31
32	DOOR LOCKS			1995	698						32
33	UPGRADE ARCADIA / LOBBY			1996	10,460						33
34	WALLVINYL			1996	2,759						34
35	HANDRAILS			1996	9,792						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CAPITALIZED LABOR-ARCADIA / LOBBY	1996	$ 7,272	$		$	$	$	37
38	REMODELING-ARCADIA / LOBBY	1996	2,466						38
39	INSTALL FIRE DOORS	1996	8,340						39
40	PHONE WIRING/JACKS	1996	1,486						40
41	SIGNS/BOARDS	1996	952						41
42	A/C WORK	1996	3,237						42
43	ELECTRICAL-ARCADIA / LOBBY	1996	3,479						43
44	INSTALL TILES	1996	1,825						44
45	INSTALL ASPHALT	1996	4,390						45
46	WALLCOVERINGS	1997	3,715						46
47	ROOFTOP TRANE UNITS	1997	12,448						47
48	INSTALL TILES/CEILING & WALLPANELS	1997	7,385						48
49	INSTALL WATER HEATER	1997	7,010						49
50	REPAIR ROOF LEAKS	1997	1,500						50
51	ELECTRICAL	1997	1,549						51
52	RETIREMENTS	1987	(86,079)						52
53	RETIREMENTS	1991	(3,037)						53
54	RETIREMENTS	1992	(6,084)						54
55	INSTALL DOORS	1997	12,737						55
56	WALLCOVERINGS	1997	1,623						56
57	INSTALL VINYL TILE	1997	11,728						57
58	A/C COMPRESSOR WORK	1997	2,257						58
59	FACILITY PLAN ALLOC	1997	2,759						59
60	REPAIR WATER LEAKS	1997	1,408						60
61	NURSES STATION GATE	1997	625						61
62	LANDSCAPING	1997	828						62
63	SIDEWALK	1997	4,023						63
64	INSTALL PATIO COVERS	1997	1,082						64
65	ROOFING	1998	1,992						65
66	HVAC	1998	3,794						66
67	TILE & CARPET	1998	6,771						67
68	FINISH/STUD	1998	3,333						68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,132,858	$ 206,337		$ 206,337	$	$ 2,697,804	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,132,858	$ 206,337		$ 206,337	$	$ 2,697,804	1
2	MASONRY WORK	1998	1,333						2
3	PLUMBING	1998	3,172						3
4	PAINTING/WALLCOVERINGS	1998	2,182						4
5	ELECTRICAL WORK	1998	2,352						5
6	CORPORATE OVERHEAD	1998	1,702						6
7	SECURITY SYSTEM	1998	22,488						7
8	IDPU PLAN REVIEW	1998	1,362						8
9	DOORS/WINDOWS	1998	2,681						9
10	GENERAL CONTRACTOR FEES	1998	1,973						10
11	FINISH/STUD	1998	9,004						11
12	MASONRY WORK	1998	21,533						12
13	FLOORING	1998	5,943						13
14	PAINTING/WALLCOVER	1998	9,311						14
15	PLUMBING	1998	1,183						15
16	ROOFING	1998	41,500						16
17	GENERAL CONTRACTORS FEES	1998	4,278						17
18	DOORS/WINDOWS	1998	3,634						18
19	ELECTRICAL	1998	1,333						19
20	HVAC	1998	5,359						20
21	SIGNAGE	1998	11,862						21
22	FLOORING	1999	1,600						22
23	WATER HEATER	1999	1,089						23
24	CARPET	1999	2,769						24
25	LEONARD MIXING VALVE	1999	3,236						25
26	FLOOR COVERING	1999	1,552						26
27	FREIGHT CARPET TILES	1999	214						27
28	BUILDING DECORATIONS	1999	23						28
29	BATH STATION TRANSFORMER	1999	3,355						29
30	MJ ROST FREIGHT	1999	616						30
31	WALLCOVERING	1999	1,325						31
32	CORNERGUARD	1999	270						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,303,092	$ 206,337		$ 206,337	$	$ 2,697,804	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,303,092	$ 206,337		$ 206,337	$	$ 2,697,804	1
2	BOILER	2000	3,076						2
3	CONCRETE & CARPENTRY	2000	30,863						3
4	PAINTING	2000	49,231						4
5	WALLCOVERING	2000	18,122						5
6	PLUMBING	2000	14,039						6
7	DEVELOPERS COST-10 BED ADDTN	2000	116,845						7
8	ADDTL COST ON CONSTRUCTION-10 BED ADDTN	2000	1,938						8
9	CARPET INSTALLATION V#3504	2000	1,805						9
10	CEILING / FLOORING	2000	25,652						10
11	AWNING FRONT ENT / SERVICE ENT	2000	2,013						11
12	CLOSET DOOR	2000	350						12
13	B G ASSEMBLY	2001	487						13
14	B G ASSEMBLY	2001	321						14
15	B G ASSEMBLY	2001	776						15
16	WATER HEATER	2001	8,452						16
17	WATER HEATER	2001	7,755						17
18	VINLY WALL COVERING	2001	433						18
19	AWNING	2001	2,013						19
20	VINLY WALL COVERING	2001	62						20
21	5/31/99 Audit Adjustment	1996	(7,272)						21
22	5/31/99 Audit Adjustment	1997	(2,758)						22
23	5/31/99 Audit Adjustment	1998	(1,702)						23
24	Border	2001	244						24
25	VWC	2001	316						25
26	Wall Coverings	2001	277						26
27	VWC	2001	200						27
28	Enterance Double Door	2001	1,305						28
29	Painting	2001	7,218						29
30	Window Treatments	2001	648						30
31	CARPET	2001	1,629						31
32	Light Fixtures	2001	3,404						32
33	Carpet	2001	870						33
34	TOTAL (lines 1 thru 33)		$ 2,591,705	$ 206,337		$ 206,337	$	$ 2,697,804	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,591,705	$ 206,337		$ 206,337	$	$ 2,697,804	1
2	Handrails	2001	1,865						2
3	Add'l Cost Smoke Shelter	2001	3,960						3
4	Smoke Shelter	2001	2,015						4
5	Painting	2001	7,200						5
6	Painting	2001	2,602						6
7	Add'l Cost Smoke Shelter	2001	600						7
8	Double Glass Doors	2001	4,050						8
9	Vinyl Tile & Sheets	2001	7,759						9
10	Wallpaper & Painting Retainage	2001	500						10
11	Wallpaper & Painting	2001	4,500						11
12	Doors	2001	4,935						12
13	Smoking Shelter	2001	5,400						13
14	VWC	2001	823						14
15	Smoke Shelter	2001	3,492						15
16	Artwork	2001	2,068						16
17	Smoke Shelter	2001	388						17
18	Carpet	2001	8,821						18
19	Smoke Shelter	2001	400						19
20	Smoke Shelter	2001	988						20
21	Window treatments	2001	593						21
22	Kitchen store room door	2001	1,380						22
23	Sidewalk & Parking Lot	2001	8,555						23
24	Shower Room Renovation	2002	655						24
25	Window treatments	2002	3,459						25
26	Carpet and Installation	2002	1,190						26
27	Artwork	2002	2,199						27
28	Renovation - OH & Int.	2002	1,905						28
29	Reno - Flooring, Painting	2002	29,775						29
30	Reno - Plumbing & Electrical	2002	37,536						30
31	Arch & Engineering Costs	2002	2,240						31
32	Arch & Engineering Costs	2002	619						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,744,179	$ 206,337		$ 206,337	$	$ 2,697,804	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,744,179	$ 206,337		$ 206,337	$	$ 2,697,804	1
2	Adjust asset #1680 - (Reno-Plumbing & Electrical)	2003	(4,164)						2
3	Exterior Renovations - Soffitt & Gutters	2002	9,112						3
4	Exterior Renovations - Soffitt & Gutters	2002	1,013						4
5	Vent Work	2002	331						5
6	Baseboard	2002	4,164						6
7	Addtn. - Carpet, VWC & Sig	2002	9,213						7
8	Addtn - Concrete test & L	2002	3,599						8
9	Addtn - Permits	2002	8,834						9
10	PLUMBING - 2003 Audit Adjustment	2003	(6,909)						10
11	DEVELOPERS COST-10 BED ADDTN - 2003 Audit Adj.	2000	(116,845)						11
12	WATER HEATER - 2003 Audit Adjustment	2001	(497)						12
13	Artwork - 2003 Audit Adjustment	2001	(2,068)						13
14	Artwork -2003 Audit Adjustment	2002	(2,199)						14
15	Renovation - O/H & Int. - 2003 Audit Adjustment	2002	(1,905)						15
16	Renovation-Roofing & Sheet Metal	2003	67,148						16
17	Renovation-General Overhead	2003	1,031						17
18	Renovation-Interest	2003	581						18
19	AWNING	2003	2,470						19
20	CREDIT ON VWC	2002	(142)						20
21	Renovation-Engineering	2004	4,880						21
22	Renovation-General Overhead	2004	10,453						22
23	Renovation-Interest	2004	138						23
24	Landscaping-Install Façade Materials	2003	23,983						24
25	GAZEBO	2003	6,215						25
26	ADD'L COST GAZEBO	2003	2,611						26
27	Doors and Downspouts	2004	7,110						27
28	Doors Retainage	2004	790						28
29	Vinyl Tile and Cove Base	2004	17,910						29
30	Vinyl Tile and Base	2005	2,974						30
31	Vinyl Tile	2005	2,974						31
32	Vinyl Tile and Cove Base	2005	10,985						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,807,968	$ 206,337		$ 206,337	$	$ 2,697,804	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,043,350	$ 88,449	$ 88,449	$		$ 716,141	71
72	Current Year Purchases	82,044						72
73	Fully Depreciated Assets			11,805	11,805			73
74	Home Office							74
75	TOTALS	$ 1,125,394	$ 88,449	$ 100,254	$ 11,805		$ 716,141	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,179,206	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 294,786	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 306,591	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,805	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,413,945	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 2,033,596	92
93			93
94			94
95		$ 2,033,596	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 19,693 Description: O2 Concentrators, Wheelchairs, Gerichairs, Electric Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	2389 hrs	$ 65,628	2,139	$ 53,483	$ 1,366	4,528	$ 120,477	1
2	Licensed Speech and Language Development Therapist	10a	988 hrs	39,399	1,085	27,134	194	2,073	66,727	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	2741 hrs	75,303	2,498	62,444	5,503	5,239	143,250	4
5	Physician Care		visits							5
6	Dental Care	39	visits			1,200			1,200	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				248,092		248,092	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-Ray, Lab, Inhal	10, Col 3, 39				27,884			27,884	13
14	TOTAL			$ 180,330	5,722	$ 172,145	$ 255,155	11,840	$ 607,630	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Decatur # 0027458 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 63,479	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (157,450))	952,650		3
4	Supply Inventory (priced at)	31,642		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,675		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,051,446	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	245,843		13
14	Buildings, at Historical Cost	2,807,968		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,125,394		16
17	Accumulated Depreciation (book methods)	(3,413,945)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	2,033,596		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,798,856	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,850,302	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 60,352	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	299,449		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,138		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Liabilities	52,538		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 489,477	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 489,477	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,360,825	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,850,302	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,327,736	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,327,736	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	976,691	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 976,691	17	
	B. Transfers (Itemize):			
18	**Change in Interdivision**	1,056,398	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1,056,398	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,360,825	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,026,656	1
2	Discounts and Allowances for all Levels	(242,791)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,783,865	3
	B. Ancillary Revenue		
4	Day Care	5,730	4
5	Other Care for Outpatients		5
6	Therapy	1,013,954	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,019,684	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,631	12
13	Barber and Beauty Care	18,080	13
14	Non-Patient Meals	484	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	249,042	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,935	19
20	Radiology and X-Ray	5,924	20
21	Other Medical Services	3,159	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 301,255	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	4,083	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,083	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,108,887	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	770,732	31
32	Health Care	2,353,387	32
33	General Administration	1,247,954	33
	B. Capital Expense		
34	Ownership	391,616	34
	C. Ancillary Expense		
35	Special Cost Centers	368,507	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,132,196	40
41	**Income before Income Taxes (line 30 minus line 40)****	976,691	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 976,691	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,787	1,962	$ 53,124	$ 27.08	1
2	Assistant Director of Nursing	6,086	6,680	148,288	22.20	2
3	Registered Nurses	7,724	8,478	171,532	20.23	3
4	Licensed Practical Nurses	25,098	27,548	450,948	16.37	4
5	CNAs & Orderlies	69,673	76,474	804,805	10.52	5
6	CNA Trainees					6
7	Licensed Therapist	5,961	6,565	180,330	27.47	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,053	7,741	71,775	9.27	10
11	Social Service Workers	5,790	6,375	100,501	15.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,160	19,991	180,135	9.01	15
16	Dishwashers					16
17	Maintenance Workers	2,558	2,827	45,381	16.05	17
18	Housekeepers	9,740	10,701	96,318	9.00	18
19	Laundry	4,201	4,640	39,484	8.51	19
20	Administrator	2,673	2,673	78,332	29.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,799	9,196	121,287	13.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,891	2,087	20,495	9.82	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	176,194	193,938	$ 2,562,735 *	$ 13.21	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	27,600	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 27,600		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laurie Brown	Administrator	0	$ 78,332
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,332

B. Administrative - Other

Description	Amount
Home Office	$ 279,864
TOTAL (agree to Schedule V, line 17, col. 3)	$ 279,864
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Tepper, Mann & German PC	Legal Fees	287
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 287

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,512
Unemployment Compensation Insurance	47,887
FICA Taxes	188,194
Employee Health Insurance	211,483
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	13,770
Employee Uniforms	1,095
Payroll Overhead Allocated	1
401K	12,865
Home Office Allocation	27,143
TOTAL (agree to Schedule V, line 22, col.8)	$ 533,950

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,590
Advertising: Employee Recruitment	6,923
Health Care Worker Background Check	
(Indicate # of checks performed 107)	2,138
Dues & Subscriptions	200
Association Dues	4,934
Advertising	20,249
Less: Non-Allowable Association Dues	(1,592)
Less: Public Relations Expense	( )
Non-allowable advertising	(17,766)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,676

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	7,184
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	840
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,024

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/04 Ending: 05/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare at Decatur # 0027458 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 4,934**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes $ 1,592**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **112**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **54,225** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **55,845**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(484)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.